COMPASS
Community Pharmacy Professionals Advancing **Safety** in Saskatchewan

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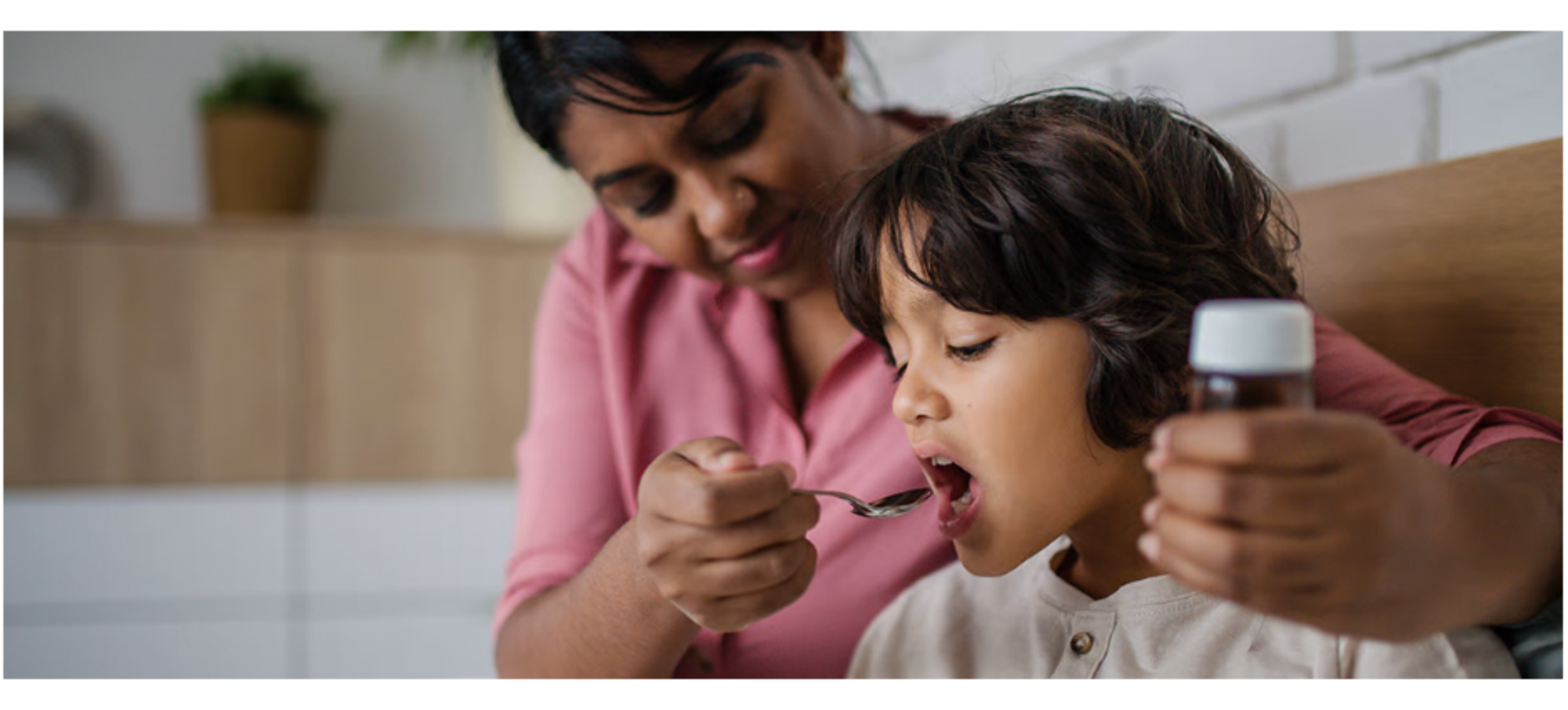


Pediatric Medication Errors in the Community: A Multi-Incident Analysis

An Institute for Safe Medication Practices (ISMP) Canada bulletin highlighted the findings from a multi-incident analysis of harmful medication incidents involving pediatric patients in the community and identifies opportunities to improve pediatric medication safety.

The analysis identified numerous factors contributing to the medication errors, categorized under three main themes, each with multiple sub-themes:

Inaccessible Pediatric-Specific Resources and Products

- Information and knowledge gaps about medication indications and/or doses for pediatric patients
- Off-label use and lack of products suitable for administration to pediatric patients

Communication Gaps

- Between members of the health care team
- Between health care providers and caregivers
- Between caregivers and children

Inaccessible Pediatric-Specific Resources and Products

- Lack of independent double checks
- Problems related to compounding process

Several opportunities exist to improve medication safety for pediatric patients, including bringing more pediatric formulations to the commercial market. Including children and adolescents in conversations about their medications can help to empower them as partners in their own care. Because specialized knowledge is required, it is essential that practitioners review medication indications and weight-based doses when prescribing or dispensing medications for the pediatric patient population.

This thematic analysis highlights key findings from incidents describing pediatric medication errors and shares selected tips to improve safety. Read the full bulletin for more details, available here.

Quality Improvement Reviews – Top Five Safety Issues

With almost 100% of community pharmacies having had a Quality Improvement Review (QIR) and the next round of QIRs soon to start, this is a good time to look at the most common safety issues identified during the QIRs. The top five safety issues are as follows:

CQI Plan Deficiencies/CQI Meetings

The lack of a CQI plan is the most common issue identified during QIRs. Even when there is a CQI plan, it is often not complete. Additionally, CQI plans are not always monitored and updated at CQI meetings. Some pharmacies are not having regular CQI meetings or documenting when a CQI meeting is being held. Pharmacy staff are not aware of the recording capabilities in the CPhIR system to record the CQI plan and CQI meeting discussion.

CDSA Related Issues

1. Regular Destruction – Some pharmacies are not aware of the requirements and therefore do not have a process in place for regular destruction of these drugs.
2. Regular Narcotic Counts/Narcotic Reconciliation – These counts are not always being completed regularly (at least quarterly).
3. Stocking of a Prohibited Drug – Exempted codeine in package sizes of greater than 50 tablets or 100mls are being ordered and stocked by pharmacies.
4. Other – Other concerns noted but with less frequency are access to narcotics by non-pharmacist staff, manual adjustments not being documented, and exempted codeine being provided as a Schedule II drugs without the pharmacist having the training.

Incident Reporting

Pharmacies report the details of the incident well, but deficiencies are noted regarding identifying the causal/contributing factors and developing system-based solutions to deal with the incident. Also, some pharmacies are only entering incidents in the corporate system and not into CPhIR.

PIP Data Quality Issues

1. Failed Transactions – Some pharmacies are not reviewing and resolving their failed transactions report daily.
2. PIP Audits – Many pharmacy managers are not aware that they are to be doing regular PIP audits. Consequently, they have not been performing the audits and ensuring that no unauthorized PIP accesses are occurring.
3. Reviewing Filled Prescription Bins Regularly – Some pharmacies are not reviewing and removing prescriptions from their filled bins regularly, leading to inaccuracy in PIP.
4. Transfers – Some pharmacies are not transferring prescriptions into their system through PIP.

Prescribing

1. Minor Ailments - Follow-up is not being documented.
2. Inappropriate PARs – Use of refill requests as the PAR or other software generated documents that do not contain all the required information e.g., rationale for prescribing, pharmacist's (prescriber) signature, etc. to meet the SCPP bylaws.

As these safety issues are identified they are recorded in the QIR form and pharmacy managers are asked to resolve the safety issue as part of the QIR follow-up. As the next round of QIRs begin, Field Officers will be looking at these issues and watching for any improvements.

Patient Safety Week 2022 – Press play on Safety Conversations

With health systems across the country under strain, the risk of unintended harm grows. Now more than ever, we need to focus on patient and health care provider safety. Together we can create safety, eliminate incidents of unintended harm, as well as act on and learn from errors.

This year's Patient Safety Week theme focuses on safer care of older adults through safety conversations and actions. When we have safety conversations, it changes the way we think about safety. Ask questions, listen, and act.

For more information, resources, and to sign up for the Patient Safety Week activities, visit the Canadian Patient Safety Week website.

Reminder: Is Your MSSA up to Date?

Pharmacies are required to complete a Medication Safety Self-Assessment (MSSA) every two years. As of last year, this became a permit requirement. If your pharmacy has not completed an MSSA within the last two years, then it is time to organize your team and complete your next MSSA.

ISMP Canada has revised the MSSA (Community Pharmacy version) and so any MSSAs that are completed will be the new version. If you have questions, please contact: jeannette.sandiford@saskpharm.ca.

COMPASS Program – MedSCIM Analysis on Harm Incidents Is Coming Soon

The Medication Safety Culture Indicator Matrix (MedSCIM) is utilized during Quality Improvement Reviews (QIRs) to assess the completeness and maturity of medication incident reports. In addition to using the MedSCIM tool during QIRs, SCPP has previously engaged ISMP Canada to perform a MedSCIM assessment on medication incidents from Saskatchewan pharmacies that have caused patient harm.

The previous reviews were completed for incidents that occurred between Dec. 1, 2017 – Jan. 31, 2019, and then Feb. 1, 2019 – Aug. 30, 2020. This third review is for incidents that have occurred from Sept. 1, 2020, to March 31, 2022. The results of this third assessment by ISMP Canada is almost complete. Please watch for the results in the next edition of directions.

Shared Learning Opportunity

Physician Error and Staff Education Problem

A prescription was received at a pharmacy for Concerta™ via fax from a doctor's office. The alphabetical quantity written on the prescription was SIXTY tablets, however the numerical quantity was written for 30 tablets with 2 refills. The prescription was entered into the software system by a pharmacy staff member as an unfilled (logged) prescription.

The prescription was not checked at that time by a pharmacist. Sometime later the patient called to request the prescription be filled. At that time, the pharmacy staff member was reviewing the active prescription on the patient profile and discovered the error regarding the wrong quantity. The incorrect prescription was inactivated, and the prescription was re-entered correctly.

Upon review of the incident by the pharmacy staff, it was determined that errors occurred at both the prescribing stage (physician error) and the order entry stage (staff education issue).

The main contributing factors that led to the incident occurring were identified as (1) a miscommunication of the drug order, due to the ambiguity between the written and numerical quantities specified and (2) staff education issue, specifically the lack of knowledge of the prescription requirements of the Prescription Review Program (PRP) and lack of feedback about errors/prevention.

The system-based solutions that were recommended were:

1. To share the details of the incident with all pharmacy staff, so they are all aware.
2. To confirm that all staff are knowledgeable of the PRP prescription requirements regarding including both the numerical and alphabetical quantities and to confirm that they are the same.
3. To ensure that all logged prescriptions entered into the system by a non-pharmacist are checked by the pharmacist.

This incident was reported here with the involvement and permission of the Saskatchewan community pharmacy

We want to hear from you!

One of the goals of COMPASS is to promote shared learning between Saskatchewan pharmacies regarding incidents, unsafe practices, and other important issues to improve pharmacy care in Saskatchewan.

One way to promote shared learning would be to report a noteworthy incident/error that occurred within your pharmacy. If your pharmacy has had an incident that would be a good learning opportunity for other Saskatchewan pharmacies, please forward it to SCPP Medication Safety at info@saskpharm.ca.

Any information regarding the pharmacy and the person who provided the details of the incidents/errors will be kept anonymous. The College encourages open sharing of incidents/errors so everyone can learn from them.

Statistics

Incorrect dose/frequency – **9,287** Statistical reports are provided to bring awareness of the importance of identifying, reporting, and discussing medication incidents. A total of **40,055** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between **Sept. 1, 2013,** and **Sept. 30, 2022**. The statistics below relate to this period.

Outcomes

- **22,479** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **16,299** reported NO HARM incidents, which means the incidents reached the patient but did not cause harm.
- **1,252** reported incidents did result in HARM, with most of these in the category of MILD or MODERATE HARM. There have been four incidents reported with an outcome of DEATH.

Incident Types – Top Three

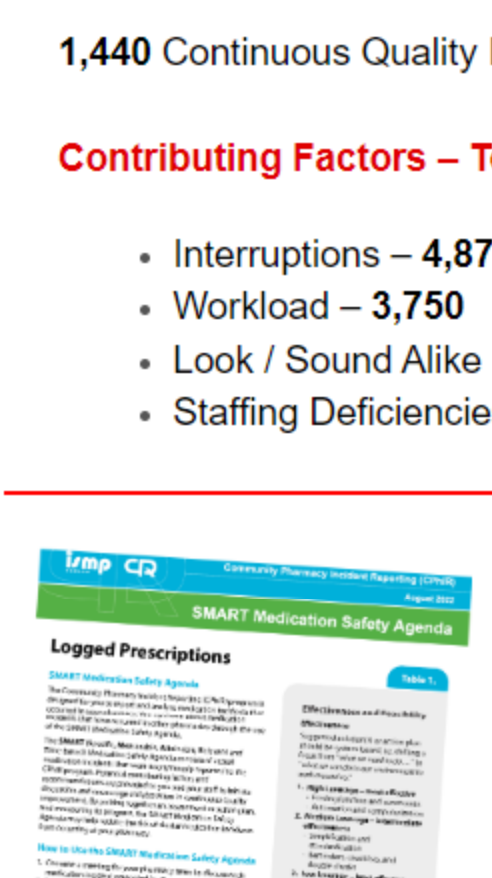
- Incorrect dose/frequency – **9,287**
- Incorrect drug – **6,830**
- Incorrect quantity – **6,538**

420 pharmacies have either started or completed their Medication Safety Self-Assessment (MSSA) online data entries.

1,440 Continuous Quality Improvement (CQI) meetings have been held.

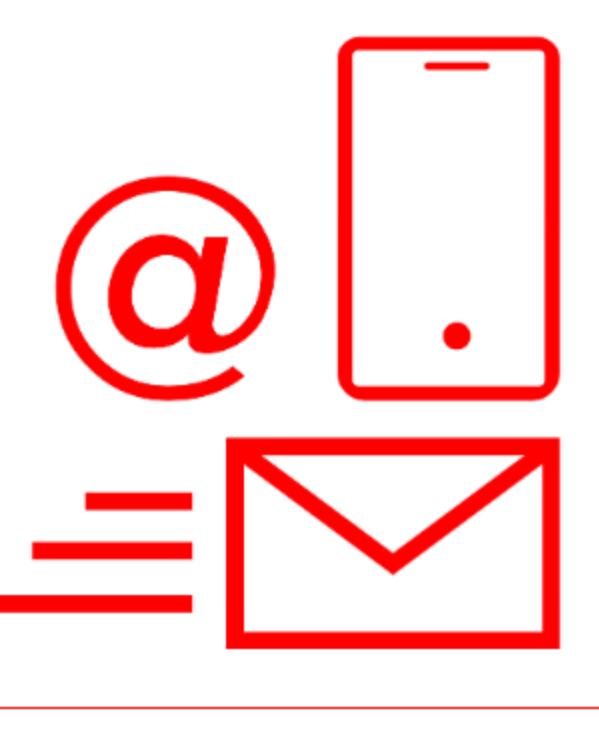
Contributing Factors – Top Four

- Interruptions – **4,879**
- Workload – **3,750**
- Look / Sound Alike Names – **2,063**
- Staffing Deficiencies – **1,893**



The SMART Medication Safety Agenda

The topic of the latest edition of the SMART Medication Agenda is **Logged Prescriptions.** All previous editions of the SMART Medication Safety Agenda can be found under the COMPASS link on the SCPP website under COMPASS Newsletters.



Contact

COMPASS: Jeannette Sandiford, Assistant Registrar – Field Operations and Quality Assurance – jeannette.sandiford@saskpharm.ca

CPhIR: ISMP Canada: cphir@ismp-canada.org

MSSA: ISMP Canada mssa@ismp-canada.org

Technical Support (COMPASS): 1-866-544-7672